

The oldest old: the newest focus in end-of-life care?

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Currently, *Swiss Medical Weekly* boasts a highly interesting and time-relevant contribution of Hug and colleagues, titled “Medical end-of-life decisions in the oldest old in Switzerland” which examines the differences between the oldest old and younger patients in terms of the frequency of various end-of-life decisions such as intensified alleviation of pain and other symptoms and, most notably, withholding and withdrawing life-sustaining treatments [1].

This study is time-relevant as it is an inescapable truth that we are being confronted with a rapidly ageing population in many countries around the world. Already more than half of all Swiss deaths concern people over the age of 80, with a further increase expected in the future. These growing numbers of people also have increasingly long trajectories of health decline – both physical and cognitive – and of chronic and degenerative illness progression, depending on their specific afflictions. Needless to say, this is putting a high strain and pressure on the medical healthcare system as well as on society and our communities to provide adequate care for our oldest old. Not only is throwing more professionals at the problem not a feasible solution, but also the number of family caregivers available to every older person with healthcare needs is set to dwindle in the near future [2].

Older people living with serious illness and multiple old-age related co-morbidities are thus regarded as a group in a highly vulnerable position when it comes to their medical care and decision making at the end of life. They are largely unempowered and prone to medical paternalism and ageism [3]. Likewise, their low functional status can lead to clinician powerlessness and therapeutic pessimism or nihilism [4]. As the authors assert: “The oldest old have been reported to have less access to specialist or palliative care, to receive adequate pain and symptom treatment less often, and to be excluded from decision making more often” [1].

Though the authors did not specifically address end-of-life care for the oldest old in Switzerland, they did find that old age seems to be a determining factor for the prevalence of some types of end-of-life decisions, regardless of cause of death, place of death, sex or marital status (all of which differ substantially across age groups). The researchers found a clear and consistent indication that life-sustaining treatment attempts (artificial nutrition and hy-

dration, antibiotics, ventilator therapy, chemotherapy and dialysis) are decided against more often among the oldest old compared with younger age groups. Also, “the proportions of patients for whom a specific treatment was taken into consideration [...] decreased with age for [most studied] types of treatment” [1].

Though this is not necessarily unequivocal evidence of old age being a decisive factor in end-of-life decision making, these findings are not very surprising as they match with (albeit scarce) international findings and debate [3, 5]. Their real merit lies in our ability to reflect about potential explanations and the issues involved. It will often be the case that in older people the cost-benefit analysis of attempting life-sustaining treatment tips over to the negative (perhaps even to the point that the treatment is not even considered): the gained quantity of life does not lead to any improvement in quality of life and/or does not weigh up to the imposed burden for the patient. Often there will even be no chance of any meaningful improvement in their situation. In those instances, there will indeed be an increased aptitude and preparedness to discuss end of life (not necessarily a “tacit” consensus that death is nearing, as the authors suggest) [1].

Above all, the older person him/herself needs to have a say in the matter, if not at the moment of decision making, then at least beforehand via, for example, advance care planning conversations. This is the best way to avoid ageist reasoning in end-of-life decisions for the oldest old, that is, attitudes that, all other things being equal, life (prolongation) in very old age is no longer as meaningful as it is in younger patients [3, 6]. Furthermore, considerations relating to the difficulties of organising adequate care, to the strain on the family or financial issues should be acknowledged but cannot readily be admitted as reasons to forgo life-sustaining treatment. As such, the age-old (no pun intended) balancing act for physicians between therapeutic tenacity on the one hand, and therapeutic nihilism and ageism on the other hand is intensified in end-of-life decision making for the oldest old. This is what makes the oldest old a fitting group for more focused research in the field of end-of-life decision making.

One other thought relating to the age disparities found in withholding treatment at the end of life: one could posit that it is not so that physicians are not aggressive enough

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when it comes to the oldest old, but can to the contrary be overly aggressive when it comes to younger people who are dying. Within current debate on the medicalisation of dying and on therapeutic tenacity [7], it is certainly a question worth pondering.

The authors have used a highly robust and trustworthy method, even though, as with any research, there are obvious limitations. Although it is in itself of limited clinical benefit, it is important to repeat this kind of population-level research longitudinally to allow for analysis of evolutions in end-of-life decision making as a monitoring and reflection tool for practice and policy. However, the above discussion shows us that large-scale surveys tell us only the broad story, providing a helicopter view of differences, but without the needed depth to definitively qualify or explain them. As such, this research forms the basis and starting point for further focused insights. For instance, examining differences in end-of-life age disparities according to care setting or region will allow us to (begin to) uncover the cultural factors that are relevant in end-of-life decision making in the oldest old, both in terms of medical culture and in terms of public, patient and family attitudes, perceptions and beliefs.

Also, as the authors concede [1], population-level research does not convey many insights on the appropriateness or the adequacy of end-of-life decision making, and the considerations underlying end-of-life decisions. A next step is to study the influencing factors and conditions in which decisions are made in the oldest old, and to gauge disparities in the quality of that decision making, from the beginning: who is involved?; to what extent and how are the patient and family involved?; on what grounds are decisions made?; to what extent do different clinical and ethical considerations come into play?

The study convincingly shows the need for more attention on this age group when it comes to end-of-life issues. The sheer number and proportion of deaths in old age (84%)

where explicit end-of-life decisions are made – and often more than one single end-of-life decision [1] – is indicative of the pervasiveness of the issue in medical practice. Managing such situations well requires adequate training, support and coping strategies. It is rarely a simple and straightforward process, involving many practical, clinical and ethical considerations and different actors, which is not made easier if it concerns a very old person. As such, the likely considerable burden for all those involved, as well as the manner in which these decisions are made, deserves all the attention it can get.

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